MMWR™

Morbidity and Mortality Weekly Report

Weekly April 5, 2002 / Vol. 51 / No. 13

Alcohol Awareness Month — April 2002

The National Council on Alcoholism and Drug Dependence (NCADD) has designated April 2002 as the 16th annual Alcohol Awareness Month. NCADD, in collaboration with CDC and other federal agencies and community organizations, will highlight the health risks associated with problem drinking and the importance of identification and intervention. The theme of this year's campaign is "Recovery: It's a Family Affair—and Everyone's Invited!"

April 11 is National Alcohol Screening Day; screening sites throughout the country will offer participants an educational presentation, a written screening questionnaire, and an opportunity to meet with a health-care professional. Online and telephone screening also will be available. Locations of screening sites are available at http://www.mentalhealthscreening.org/alcohol.htm, telephone, 800-405-9200. Press kits, fact sheets, and information about "Alcohol-Free Weekend" (April 5–7) are available at http://www.ncadd.org.

This issue of *MMWR* presents findings from the Behavioral Risk Factor Surveillance System regarding alcohol consumption among women of childbearing age in the United States, which indicate that frequent drinking and binge drinking during pregnancy continue to pose a risk to the healthy pregnancy outcomes of many women. CDC is conducting a comprehensive public health research program to prevent alcohol-exposed pregnancies and provide effective interventions for persons with fetal alcohol syndrome and other disorders caused by prenatal alcohol exposure. Information about CDC's programs and the health effects of prenatal alcohol exposure is available at http://www.cdc.gov/ncbddd/fas. Additional information is available at http://www.niaaa.nih.gov and at http://www.samhsa.gov.

Alcohol Use Among Women of Childbearing Age — United States, 1991–1999

Prenatal exposure to alcohol is one of the leading preventable causes of birth defects, mental retardation, and neurodevelopmental disorders in the United States (*1*). One of the national health objectives for 2010 is to decrease alcohol use among pregnant women to 94% (*2*). During 1991–1995, alcohol use by pregnant women increased substantially, and alcohol use by nonpregnant women of childbearing age increased slightly (*3*). To characterize trends in alcohol use among women of childbearing age, CDC analyzed representative survey data from the Behavioral Risk Factor Surveillance System (BRFSS) during 1991–1999. This report summarizes the results of the analysis, which indicate that the rate of any alcohol use (i.e., at least one drink) during pregnancy has declined since 1995. However, rates of binge drinking (i.e., ≥5 drinks on any one occasion) and frequent drinking (i.e., ≥7 drinks per week or ≥5 drinks on any one occasion) during pregnancy have not declined among nonpregnant women of childbearing age. Health-care providers should routinely screen women of childbearing age for alcohol use and counsel them about the adverse effects of alcohol use during pregnancy.

BRFSS is an ongoing, state-based, random-digit–dialed telephone survey of the noninstitutionalized U.S. civilian population aged ≥18 years. Data were analyzed for women aged 18–44 years in all 50 states. Women were asked about their

INSIDE

276 Update: Influenza Activity — United States, 2001–02 Season
279 **Suspected Cutaneous Anthrax in a Laboratory Worker — Texas, 2002**
281 Imported Dengue — United States, 1999 and 2000

CENTERS FOR DISEASE CONTROL AND PREVENTION

SAFER • HEALTHIER • PEOPLE™

MMWR™

Morbidity and Mortality Weekly Report

Weekly April 5, 2002 / Vol. 51 / No. 13

Alcohol Awareness Month — April 2002

The National Council on Alcoholism and Drug Dependence (NCADD) has designated April 2002 as the 16th annual Alcohol Awareness Month. NCADD, in collaboration with CDC and other federal agencies and community organizations, will highlight the health risks associated with problem drinking and the importance of identification and intervention. The theme of this year's campaign is "Recovery: It's a Family Affair—and Everyone's Invited!"

April 11 is National Alcohol Screening Day; screening sites throughout the country will offer participants an educational presentation, a written screening questionnaire, and an opportunity to meet with a health-care professional. Online and telephone screening also will be available. Locations of screening sites are available at http://www.mentalhealthscreening.org/alcohol.htm, telephone, 800-405-9200. Press kits, fact sheets, and information about "Alcohol-Free Weekend" (April 5–7) are available at http://www.ncadd.org.

This issue of *MMWR* presents findings from the Behavioral Risk Factor Surveillance System regarding alcohol consumption among women of childbearing age in the United States, which indicate that frequent drinking and binge drinking during pregnancy continue to pose a risk to the healthy pregnancy outcomes of many women. CDC is conducting a comprehensive public health research program to prevent alcohol-exposed pregnancies and provide effective interventions for persons with fetal alcohol syndrome and other disorders caused by prenatal alcohol exposure. Information about CDC's programs and the health effects of prenatal alcohol exposure is available at http://www.cdc.gov/ncbddd/fas. Additional information is available at http://www.niaaa.nih.gov and at http://www.samhsa.gov.

Alcohol Use Among Women of Childbearing Age — United States, 1991–1999

Prenatal exposure to alcohol is one of the leading preventable causes of birth defects, mental retardation, and neurodevelopmental disorders in the United States (*1*). One of the national health objectives for 2010 is to decrease alcohol use among pregnant women to 94% (*2*). During 1991–1995, alcohol use by pregnant women increased substantially, and alcohol use by nonpregnant women of childbearing age increased slightly (*3*). To characterize trends in alcohol use among women of childbearing age, CDC analyzed representative survey data from the Behavioral Risk Factor Surveillance System (BRFSS) during 1991–1999. This report summarizes the results of the analysis, which indicate that the rate of any alcohol use (i.e., at least one drink) during pregnancy has declined since 1995. However, rates of binge drinking (i.e., ≥5 drinks on any one occasion) and frequent drinking (i.e., ≥7 drinks per week or ≥5 drinks on any one occasion) during pregnancy have not declined among nonpregnant women of childbearing age. Health-care providers should routinely screen women of childbearing age for alcohol use and counsel them about the adverse effects of alcohol use during pregnancy.

BRFSS is an ongoing, state-based, random-digit–dialed telephone survey of the noninstitutionalized U.S. civilian population aged ≥18 years. Data were analyzed for women aged 18–44 years in all 50 states. Women were asked about their

INSIDE

276 Update: Influenza Activity — United States, 2001–02 Season
279 **Suspected Cutaneous Anthrax in a Laboratory Worker — Texas, 2002**
281 Imported Dengue — United States, 1999 and 2000

CENTERS FOR DISEASE CONTROL AND PREVENTION

SAFER • HEALTHIER • PEOPLE™

The *MMWR* series of publications is published by the Epidemiology Program Office, Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services, Atlanta, GA 30333.

SUGGESTED CITATION
Centers for Disease Control and Prevention. [Article Title]. MMWR 2002;51:[inclusive page numbers].

Centers for Disease Control and Prevention
David W. Fleming, M.D.
Acting Director

Julie L. Gerberding, M.D.
Acting Deputy Director for Science and Public Health

Dixie E. Snider, Jr., M.D., M.P.H.
Associate Director for Science

Epidemiology Program Office
Stephen B. Thacker, M.D., M.Sc.
Director

Office of Scientific and Health Communications
John W. Ward, M.D.
Director
Editor, MMWR *Series*

David C. Johnson
Acting Managing Editor, MMWR *(Weekly)*

Jude C. Rutledge
Jeffrey D. Sokolow, M.A.
Writers/Editors, MMWR *(Weekly)*

Lynda G. Cupell
Malbea A. Heilman
Beverly J. Holland
Visual Information Specialists

Michele D. Renshaw
Erica R. Shaver
Information Technology Specialists

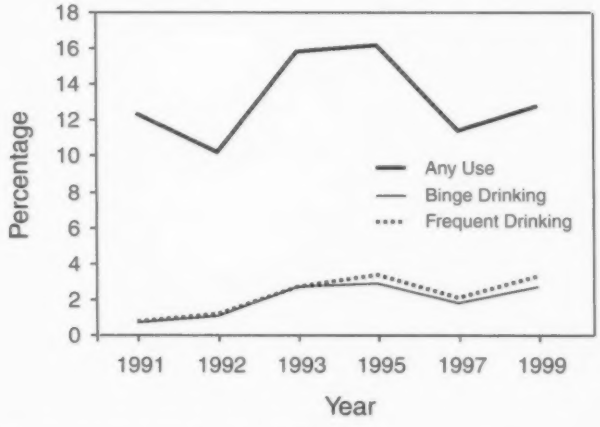
Division of Public Health Surveillance and Informatics
Notifiable Disease Morbidity and 122 Cities Mortality Data
Carol M. Knowles
Deborah A. Adams
Felicia J. Connor
Patsy A. Hall
Mechele A. Hester
Pearl C. Sharp

use of alcohol during the 30 days preceding the survey. Three alcohol drinking patterns were examined: any use, binge drinking, and frequent drinking. Information on alcohol use was obtained every year through 1993 and every other year thereafter.

Sample data were weighted to reflect general population estimates, and standard errors were calculated by using SUDAAN. Linear regression models were used to examine temporal trends. To determine statistical significance, the inverse of the variance estimates was used for weights. Multivariate logistic analysis was conducted to examine the age, race, education level, employment, and marital status of pregnant and nonpregnant women by patterns of alcohol use. Because of the limited number of pregnant women surveyed, data were combined for 1995–1999 for the analysis of the characteristics of pregnant women who engaged in these risk behaviors.

During 1995–1999, a total of 4,695 (4.3%) of the 107,141 women aged 18–44 years who were interviewed about their alcohol use during the month preceding the survey reported that they were pregnant at the time of the interview. The prevalence of any alcohol use among pregnant women increased from 12.4% in 1991 to 16.3 % in 1995 (Figure 1) (*3*). Compared with 1995 data, prevalence was lower in 1997 (11.4%) and 1999 (12.8%). In contrast, the rates of binge drinking and frequent drinking reported by pregnant women in 1995 remained substantially unchanged in 1997 and 1999: binge drinking rates were 2.9% in 1995, 1.8% in 1997, and 2.7% in 1999, and frequent alcohol use rates were 3.5% in 1995, 2.1% in 1997, and 3.3% in 1999. Among nonpregnant

FIGURE 1. Weighted percentage of pregnant women aged 18–44 years who reported alcohol use — United States, 1991–1999*



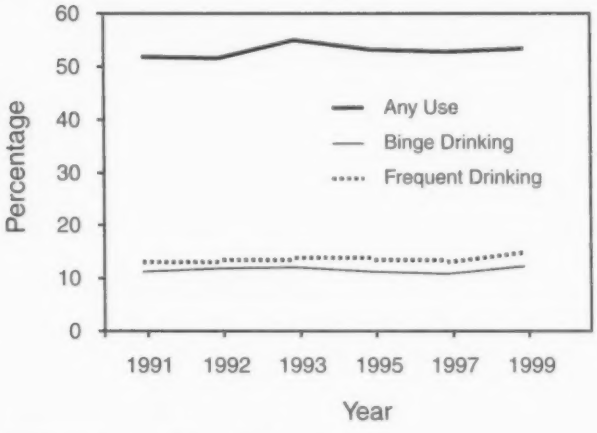
* Data not collected in 1994, 1996, 1998.

women who reported any alcohol use (Figure 2), rates remained stable: 53.2% in 1995, 52.8% in 1997, and 53.3% in 1999. Binge drinking rates among this population were 11.2% in 1995, 10.8% in 1997, and 12.3% in 1999.

In comparison with other pregnant women, pregnant women who reported any alcohol use, binge drinking, and frequent drinking were more likely to be aged >30 years, employed, and unmarried (Table 1). Nonpregnant women who reported any alcohol use, binge drinking, and frequent drinking had similar employment and marital status as pregnant women. In addition, nonpregnant women reporting any alcohol use were more likely to be white and to have higher education levels than women who did not engage in this behavior; nonpregnant women who reported binge drinking and frequent drinking tended to be aged <30 years.

Reported by: *JS Sidhu, MD, RL Floyd, DSN, Div of Birth Defects and Developmental Disabilities, National Center on Birth Defects and Developmental Disabilities, CDC.*

FIGURE 2. Weighted percentage of nonpregnant women aged 18–44 years who reported alcohol use — United States, 1991–1999*



* Data not collected in 1994, 1996, 1998.

Editorial Note: The findings in this report indicate that overall rates of any alcohol use during pregnancy declined since 1995. However, rates of binge drinking and frequent drinking during pregnancy did not decline and remain higher than the 2010 Healthy People objectives. These findings are consistent with those from the National Household Survey on Drug Abuse (*4*). Among nonpregnant women in their peak childbearing years, the use of alcohol, including the riskier practices of frequent and binge drinking, has not declined (*5,6*). Prenatal drinking patterns are highly predictive of alcohol use during pregnancy (*4*).

Pregnant women who are unmarried and older tend to have the highest rates of alcohol use (*4*). Women who drink alcohol are more likely than other women to be white, unmarried, younger, and working full time outside the home (*7*). Age is one characteristic that distinguishes heavier drinking patterns among pregnant and nonpregnant women. In this analysis, binge drinking and frequent drinking during pregnancy

TABLE 1. Estimated percentage* of pregnant and nonpregnant women aged 18–44 years who reported alcohol use, by selected characteristics — United States, 1995–1999

	Any use						Binge drinking†						Frequent drinking§					
	Pregnant¶			Nonpregnant**			Pregnant			Nonpregnant			Pregnant			Nonpregnant		
Characteristic	%	OR††	CI§§	%	OR	CI	%	OR	CI	%	OR	CI	%	OR	CI	%	OR	CI
Age (yrs)																		
18–30	11.8	0.6	(0.5–0.7)	54.1	1.1	(1.0–1.1)	2.2	0.6	(0.4–1.0)	15.5	1.7	(1.6–1.8)	2.7	0.6	(0.4–1.0)	17.3	1.4	(1.4–1.5)
31–44	16.8	1.0	Referent	52.3	1.0	Referent	3.0	1.0	Referent	8.1	1.0	Referent	3.5	1.0	Referent	10.8	1.0	Referent
Race																		
White	12.8	0.9	(0.7–1.1)	57.9	1.9	(1.8–1.9)	2.4	1.1	(0.6–2.2)	13.1	2.2	(2.0–2.4)	2.7	0.9	(0.5–1.7)	15.5	2.1	(1.9–2.2)
Nonwhite¶¶	14.8	1.0	Referent	41.8	1.0	Referent	2.6	1.0	Referent	7.4	1.0	Referent	3.5	1.0	Referent	9.2	1.0	Referent
Education																		
<High school	9.8	1.0	Referent	33.6	1.0	Referent	2.2	1.0	Referent	9.3	1.0	Referent	2.8	1.0	Referent	10.3	1.0	Referent
≥High school	14.0	1.5	(1.0–2.3)	55.3	2.0	(1.8–2.1)	2.5	0.9	(0.4–2.0)	11.6	1.1	(1.0–1.2)	3.0	0.9	(0.5–1.9)	14.1	1.2	(1.1–1.4)
Employed																		
Yes	15.5	1.5	(1.1–1.9)	57.1	1.5	(1.5–1.6)	3.3	2.7	(1.4–5.3)	12.2	1.3	(1.2–1.4)	3.8	2.3	(1.3–4.1)	14.7	1.3	(1.2–1.4)
No	10.7	1.0	Referent	44.4	1.0	Referent	1.3	1.0	Referent	9.7	1.0	Referent	1.8	1.0	Referent	11.5	1.0	Referent
Married																		
Yes	11.2	1.0	Referent	50.3	1.0	Referent	1.7	1.0	Referent	7.3	1.0	Referent	2.0	1.0	Referent	9.3	1.0	Referent
No	20.1	2.3	(1.8–3.0)	56.6	1.4	(1.4–1.5)	4.8	3.7	(2.0–6.6)	16.5	2.3	(2.2–2.5)	5.9	3.6	(2.1–6.1)	19.1	2.3	(2.1–2.4)

* Adjusted for age, race, education, employment, and marital status.
† ≥5 drinks on one occasion.
§ ≥7 drinks/week or binge.
¶ 1995 = 1,378, 1997 = 1,429, 1999 = 1,888.
** 1995 = 29,149, 1997 = 33,694, 1999 = 39,603.
†† Odds ratio.
§§ Confidence interval.
¶¶ Includes Asian/Pacific Islander, American Indian/Alaska Native, black, and Hispanic.

were more common in women aged 30–44 years, but among nonpregnant women, these drinking patterns were more likely to occur among women <30 years. Women aged <30 years tend to reduce alcohol use when they become aware they are pregnant, but women aged ≥30 years are less likely to reduce alcohol use after learning they are pregnant (*5*), indicating greater alcohol dependency and difficulty in reducing or eliminating alcohol use during pregnancy (*8*).

The findings in this report are subject to at least three limitations. First, BRFSS data are self-reported and might be subject to reporting biases, especially among pregnant women who are aware that alcohol use is not advised. Second, because BRFSS is a telephone survey of the noninstitutionalized U.S. population, homeless women, women in homes without telephones, and women who are institutionalized were not surveyed. Both of these limitations could have an impact on prevalence rates. Finally, because the proportion of pregnant women in this sample who were drinkers was limited, these estimated prevalence rates are subject to variability.

Heavy alcohol use before pregnancy is highly predictive of continued use, chiefly among older prenatal patients. Because levels of binge and frequent drinking among nonpregnant women have not declined, all women of childbearing age should be warned about the adverse effects of alcohol use, especially high-risk drinking patterns (i.e., binge drinking and frequent drinking), and health-care providers should learn effective techniques for screening for, and intervening with, binge and frequent drinkers.

Routine screening can enhance women's present and future health and might avert early prenatal exposure before women become aware of pregnancy. Using brief intervention techniques and encouraging patients to seek social support through friends, family, and community groups might encourage women to abstain from alcohol use during pregnancy (*9*).

Potential disparities in health knowledge of pregnant women might be a contributing factor to sustained levels of binge and frequent drinking. To ensure more uniform dissemination of prenatal alcohol prevention messages, CDC, in collaboration with the Association of Schools of Public Health, will conduct targeted media campaigns to increase public awareness of the adverse effects of alcohol use during pregnancy among diverse geographic and racial/ethnic populations and among younger women.

Additional information about CDC's activities to prevent alcohol-exposed pregnancies is available at www.cdc.gov/ncbddd/fas.

References

1. Jacobs EA, Copperman SM, Jeffe A, Kulig J. Fetal alcohol syndrome and alcohol related neurodevelopmental disorders. Pediatrics 2000;106:358–61.
2. US Department of Health and Human Services. Healthy People 2010 (conference ed, in 2 vols). Washington, DC: US Department of Health and Human Services, 2000.
3. CDC. Alcohol consumption among pregnant and childbearing-aged women—United States, 1991 and 1995. MMWR 1997;46:346–50.
4. US Department of Health and Human Services. Summary of findings from the 1999 National Household Survey on Drug Abuse. Washington, DC: US Department of Health and Human Services, 2000.
5. Ebrahim SH, Diekman ST, Floyd LR, Decoufle P. Pregnancy-related alcohol use among women in the United States—1988–95. Prenat Neonat Med 1999;4:39–46.
6. Ebrahim SH, Diekman ST, Floyd LR. Comparison of binge drinking among pregnant and nonpregnant women, United States, 1991–1995. Amer J Obstet Gynecol 1999;180:1–7.
7. Day NL, Cottreau CM, Richardson GA. The epidemiology of alcohol, marijuana, and cocaine use among women of childbearing age and pregnant women. Clin Obstet Gynecol 1993;36:232–45.
8. Grant BF, Douison DA. Age at onset of alcohol use and its association with DSM-IV drug abuse and dependence: results from the National Longitudinal Alcohol Epidemiologic Survey. J Subst Abuse 1998;10:163–73.
9. Ried K Hester, William R Miller, eds. Handbook of alcoholism treatment approaches: effective alternatives, 2nd ed. Needham Heights, Massachusetts: Allyn and Bacon, 1995.

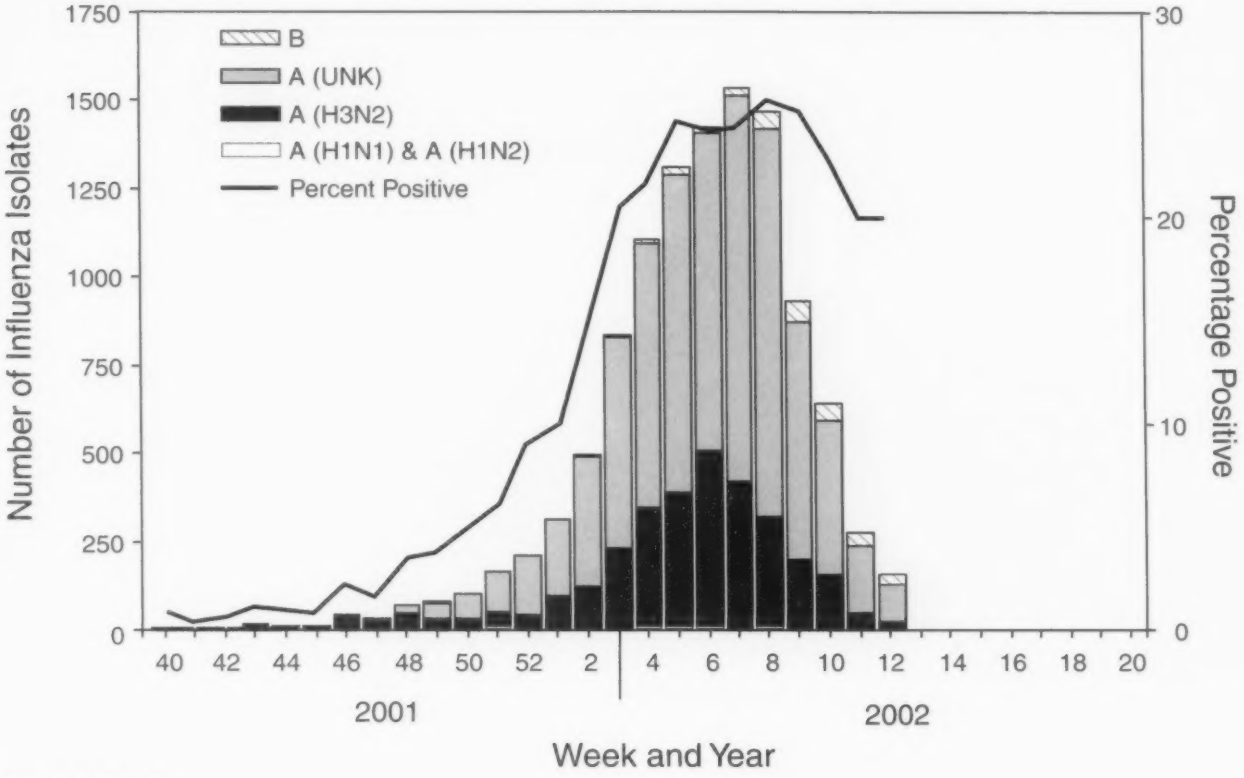
Update: Influenza Activity — United States, 2001–02 Season

Although data collected from the four components of the CDC influenza surveillance system* are preliminary, national influenza activity appears to have peaked during the week ending February 23, 2002 (week 8). During the 2000–01 and 1999–2000 influenza seasons, peak activity occurred during week 4 and week 51, respectively. The viruses most commonly isolated during the 2001–02 season have been influenza A (H3N2). These viruses were well-matched antigenically by the 2001–02 influenza A (H3N2) strain in the vaccine. This report summarizes influenza activity in the United States† during September 30, 2001–March 23, 2002, and updates previous summaries from this season (*1,2*).

For the weeks ending January 26 (week 4) through March 23 (week 12), the period covered since the last report, the percentage of respiratory specimens testing positive for influenza viruses, a key indicator of the level of influenza activity, ranged from 17.6% (week 4) to 25.9% (week 8) (Figure 1). Since September 30, 2001, World Health Organization (WHO) and National Respiratory and Enteric Virus Surveillance System (NREVSS) collaborating laboratories in the United States tested 72,877 specimens for influenza viruses;

*WHO and NREVSS collaborating laboratories, national sentinel physician influenza-like illness tracking system, 122 Cities Mortality Reporting System, and state and local health department reporting.
†As of April 3, 2002.

FIGURE 1. Number and percentage of specimens testing positive for influenza, World Health Organization and National Enteric and Respiratory Virus Surveillance System Collaborating Laboratories — United States, 2001–02 Season*



* As of April 3, 2002.

12,017 (16.5%) were positive, of which 11,599 (97%) were influenza A viruses and 418 (3%) were influenza B viruses. Approximately one third of the influenza B viruses were isolated in the Mid-Atlantic region of the United States. Of the 3,479 influenza A viruses that have been subtyped, 3,426 (98%) were H3 viruses, and 53 (2%) were H1 viruses.

CDC has characterized antigenically 391 influenza isolates collected in the United States since September 30. Of these, 279 were influenza A (H3N2) viruses, 14 were influenza A (H1) viruses, and 96 were influenza B viruses. Of the 14 A (H1) viruses, five were A (H1N1) viruses and nine were A (H1N2) viruses. These nine A (H1N2) viruses came from patient specimens collected in Wisconsin in December 2001. Two other A (H1N2) viruses were isolated from patient specimens collected during July and September in Texas and Nevada, respectively. The influenza A (H3N2) and A (H1) viruses were similar antigenically to the vaccine strains A/Panama/2007/99 (H3N2) and A/New Caledonia/20/99 (H1N1) viruses, respectively.

Influenza B viruses currently circulating worldwide can be divided into two antigenically distinct lineages: B/Yamagata/16/88 and B/Victoria/2/87. B/Yamagata viruses have circulated widely since 1990, and the B component of the current influenza vaccine belongs to this lineage. Since 1991, B/Victoria viruses had not been identified outside of Asia. However, since March 2001, B/Victoria lineage viruses have been identified in many countries, including the United States. Of the 96 U.S. influenza B viruses characterized antigenically this season, 53 were of the B/Yamagata lineage, and 43 were of the B/Victoria lineage. Of the 53 B/Yamagata lineage viruses, 22 were similar to the vaccine strain, B/Sichuan/379/99, and 31 demonstrated reduced titers to ferret antisera produced against B/Sichuan/379/99.

During January 20–March 23, 2002, the weekly percentage of patient visits for influenza-like illness (ILI)[§] reported

[§] Temperature of ≥100.0°F (≥37.8°C) and either cough or sore throat in the absence of a known cause.

by U.S. sentinel physicians in 47 states ranged from 1.7% to 3.5%. For the week ending March 23, the percentage of patient visits for ILI was 1.7%, below the national baseline of 1.9%[¶]. During the same week, influenza activity[**] reported by state epidemiologists was widespread in three states (Arizona, Missouri, and Vermont), and regional in 17 states (California, Idaho, Illinois, Louisiana, Michigan, Montana, Nebraska, New York, Ohio, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Washington, and Wisconsin). Twenty-seven states, New York City, and Washington, D.C. reported sporadic influenza activity, and Alaska and Georgia reported no influenza activity. One state did not report.

During the week ending March 23, the 122 Cities Mortality Reporting System attributed 8.8% of recorded deaths to pneumonia and influenza (P&I). This percentage was above the epidemic threshold[††] of 8.2% for that week. The percentage of P&I deaths was above the epidemic threshold during weeks 9 through 12.

Reported by: *WHO Collaborating Center for Surveillance, Epidemiology, and Control of Influenza; A Postema, MPH, L Brammer, MPH, H Hall, A Klimov, PhD, K Fukuda, MD, N Cox, PhD, Div of Viral and Rickettsial Diseases, National Center for Infectious Diseases; S Harper, MD, EIS Officer, CDC.*

Editorial Note: Influenza activity in the United States during the current season increased steadily during December–January, peaked in February, and is declining nationwide. Influenza activity has peaked during February or later during 15 of the last 25 seasons. Last season, influenza activity peaked in January. In recent weeks, influenza B virus activity has increased in certain areas of the country, and both influenza A and B viruses might continue to circulate during April.

During 2001–2002, influenza A (H1N2) viruses have been isolated from several countries, including the United States (*3*). These new A (H1N2) viruses appear to have resulted from reassortment of the genes of currently circulating influenza A (H1N1) and A (H3N2) subtypes. Because hemagglutinin proteins of the A (H1N2) viruses are similar to those of the currently circulating A (H1N1) viruses, and the neuraminidase proteins are similar to those of the current A (H3N2) viruses, the current vaccine should provide good protection against the new A (H1N2) viruses (*4*). No information indicates that A (H1N2) viruses are causing more severe illness than other influenza A viruses, and no unusual increases in influenza activity have been associated with these viruses. Similar reassortment A (H1N2) viruses were isolated in China during the 1988–89 influenza season but had not been reported in other parts of the world since that time. Whether the new A (H1N2) viruses will persist is uncertain.

The Food and Drug Administration's Vaccine and Related Biological Products Advisory Committee (VRBPAC) recommended inclusion of the A/New Caledonia/20/99-like (H1N1), A/Moscow/10/99-like (H3N2), and B/Hong Kong/330/2001-like viruses in the 2002–03 trivalent influenza vaccine for the United States (*5*). The A (H1N1) and A (H3N2) components are the same as those used in the 2001–02 season vaccine. The influenza B component of the 2002–03 season vaccine is new and will be a virus of the B/Victoria lineage. The emergence of B/Victoria lineage influenza viruses around the world led to the recommended change in the B strain to be included in the 2002–03 vaccine. The B component of the current influenza vaccine is expected to provide lower levels of protection against viruses of the B/Victoria lineage.

CDC annually collects and reports U.S. influenza surveillance data during October–May. During this period, the information is updated weekly and is available through CDC voice information, 888-232-3228, fax information, 888-232-3299 (request document number 361100), or at http://www.cdc.gov/ncidod/diseases/flu/weekly.htm.

Acknowledgment

This report is based on data contributed by participating state and territorial epidemiologists and state health laboratories, WHO collaborating laboratories, National Respiratory and Enteric Virus Surveillance System laboratories, Sentinel Physicians Influenza Surveillance System, Div of Public Health Surveillance and Informatics, Epidemiology Program Office, Div of Vital Statistics, CDC.

[¶] The national baseline was calculated as the mean percentage of visits for ILI during noninfluenza weeks plus two standard deviations. Because of wide variability in regional level data, calculating region-specific baselines is not possible, and to apply the national baseline to regional level data is not appropriate.

[**] Levels of activity: 1) *no activity*, 2) *sporadic*—sporadically occurring ILI or laboratory-confirmed influenza with no outbreaks detected, 3) *regional*—outbreaks of ILI or laboratory-confirmed influenza in counties with a combined population of <50% of the state's population, and 4) *widespread*—outbreaks of ILI or laboratory-confirmed influenza in counties with a combined population of ≥50% of the state's population.

[††] The expected baseline proportion of P&I deaths reported by the 122 Cities Mortality Reporting System is projected by using a robust regression procedure in which a periodic regression model is applied to the observed percentage of deaths from P&I since 1983. The epidemic threshold is 1.654 standard deviations above the seasonal baseline. Before the 1999–2000 season, a new case definition for a P&I death was introduced. During summer 2000, the baseline and epidemic thresholds were adjusted manually to account for these changes in case definition. For the 2001–02 season, sufficient data have been collected by using the new case definition to allow projection of the baseline using the regression procedure employed before the 2000–01 season.

References

1. CDC. Influenza activity—United States, 2001–02 season. MMWR 2002;51:78–80,91.
2. CDC. Influenza activity—United States, 2001–02 season. MMWR 2001;50:1084–6.
3. World Health Organization. Influenza A(H1N2) viruses. Wkly Epidemiol Rec 2002;77:77–80.
4. World Health Organization. Recommended composition of influenza virus vaccines for use in the 2002–2003 season. Wkly Epidemiol Rec 2002;77:57–68.
5. Food and Drug Administration. VRBPAC preliminary meeting summary for March 6, 2002. Available at http://www.fda.gov/ohrms/dockets/ac/02/minutes/3842m1_preliminary.htm.

Suspected Cutaneous Anthrax in a Laboratory Worker — Texas, 2002

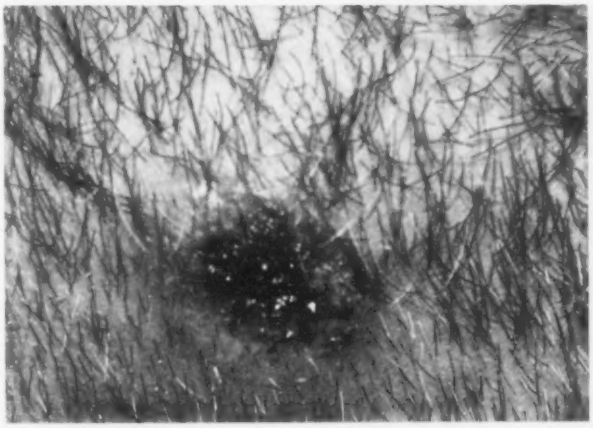
On March 6, 2002, CDC's National Institute for Occupational Safety and Health (NIOSH) received a request for a health hazard evaluation from the director of Laboratory A to assist in the evaluation of a worker who had been diagnosed with cutaneous anthrax. Laboratory A, a provisionally approved Laboratory Response Network level B laboratory, had been processing environmental samples for *Bacillus anthracis* in support of CDC investigations of the bioterrorist attacks in the United States during fall 2001. Since March 7, CDC has interviewed the ill laboratory worker and other workers at the laboratory and conducted environmental assessments of the workplace. This report summarizes the epidemiologic and environmental investigation of this case, which indicates that the likely source of exposure was the surface of vials containing *B. anthracis* isolates that the worker placed in a freezer on March 1. Laboratory workers handling specimens of *B. anthracis* should follow recommended procedures to minimize the risk of *B. anthracis* transmission and anthrax.

The laboratory worker was one of three employees of Laboratory A who had primary responsibility for processing environmental *B. anthracis* specimens. Neither this worker nor any of the other approximately 40 employees of Laboratory A had received anthrax vaccine. The laboratory worker did not handle *B. anthracis*-containing samples or cultures during February 19–28. On February 28, he cut a small bump on his right jaw while shaving, which bled briefly and then became itchy and irritated. On March 1, he assisted a co-worker moving vials containing aliquots of confirmed *B. anthracis* isolates from the biological safety cabinet (BSC) in the main laboratory to the freezer in an adjacent room. The co-worker had transferred the isolates from blood agar plates to the vials by collecting the growth with a swab. The co-worker removed the vials from the BSC and handed them to the patient. Without gloves, the patient took the vials from the co-worker, placed the vials in the freezer, and then washed his hands with soap and water. During the next 2–3 days, the worker's facial wound increased in size and developed a scab. He also reported right cervical adenopathy, a low-grade fever, and swelling and erythema on his right cheek and neck. The patient's health-care provider obtained a swab of the area underneath the scab and of the area under a vesicle, without cleansing the skin first. The health-care provider made a presumptive diagnosis of cutaneous anthrax and the patient was administered a 2-week course of ciprofloxacin.

The culture of this specimen was positive for *B. anthracis* on testing at Laboratory A and CDC. Because of culture results, the patient was admitted to the hospital on March 5 and treated with intravenous ciprofloxacin and doxycycline pending antimicrobial susceptibility testing. The lesion developed the characteristic eschar of cutaneous anthrax (Figure 1). A chest radiograph performed on admission demonstrated possible fullness of the mediastinum, but computed tomography of the chest was normal. The isolate was susceptible to ciprofloxacin and doxycycline, and the patient continued receiving ciprofloxacin. The patient's symptoms improved during hospitalization, and he was discharged on March 9. Serologic studies for antibodies to *B. anthracis* are planned.

On March 5, Laboratory A's certified industrial hygienist (CIH) performed environmental sampling of both Laboratory A and the patient's residence. Seven wipe samples were taken at the laboratory (i.e., the top of the vials the patient had handled, the key to the freezer where the vials were placed, the doorknob of the freezer room, the centrifuge where specimens are prepared, the two BSCs where specimens are handled,

FIGURE 1. Anthrax lesion on patient's right jaw



Photo/CDC File

and surfaces in the patient's office in Laboratory A), seven were taken at the patient's residence. The CIH then cleaned surfaces and equipment throughout the laboratory and the patient's residence by using a disinfectant containing a phenolic and a quaternary ammonium compound, which are not sporicidal. The environmental samples were analyzed in Laboratory A. All samples were negative except the wipe sample collected from tops of the vials that the patient had handled, which was positive for *B. anthracis*. Confirmation of the vial top specimen at CDC is planned.

Workers reported that specimen processing of environmental samples suspected of containing *B. anthracis* is done under Biosafety Level 3 (BSL-3) conditions (*1*). These samples, including swab, wipe, dust (collected onto filter media by a vacuum), and air samples, are opened in a Class II, Type A BSC in a room designated for acid-fast bacillus specimens (AFB room). Personal protective equipment (PPE) for procedures performed in this room includes disposable, fluid-resistant laboratory coats, gloves, and either a NIOSH-certified N95 or P100 disposable, filtering-facepiece respirator, which are disposed of into a biohazard container before exiting the room. Work with purified *B. anthracis* cultures is performed in a separate BSC located in the main laboratory room. PPE at this workstation consists of gloves and a laboratory coat. Aliquots of confirmed isolates of *B. anthracis* are placed in vials and stored in a locked freezer in a room located off the main laboratory. A 10% bleach solution is routinely used to decontaminate surfaces after processing specimens potentially containing *B. anthracis*. However, because bleach caused labels to become dislodged, storage vials had been sprayed with 70% isopropyl alcohol instead of being wiped with bleach. By the time of the CDC site visit, Laboratory A personnel had obtained labels for storage vials that would not dislodge with bleach.

On March 7 and 8, CDC interviewed Laboratory A workers; none reported illness among other employees or their family members. CDC also conducted environmental sampling at Laboratory A on March 7, consisting of 40 surface wipe and 36 air samples. Wipe samples obtained with sterile polyester/rayon pads, moistened with sterile water, were collected from various surfaces in the laboratory and in the adjacent office area, including desks, flooring, door knobs, BSCs, heating, ventilation, air-conditioning return air grills, and laboratory equipment (including the centrifuge and shaker used for processing environmental samples). Air samples were collected in three locations in the laboratory: the AFB room, the area adjacent to the BSC used for anthrax work, and the general microbiology area; two locations in the adjacent office area; and outdoors. All environmental samples were negative for *B. anthracis* at CDC.

On March 8, CDC performed a building assessment, including a ventilation survey, airflow distribution mapping, and BSC characterization. The AFB room was not under negative pressure in relation to adjacent areas of the main laboratory; however, the laboratory was under negative pressure relative to the outside and to the adjacent office areas. The BSCs were functioning adequately.

Reported by: *TA Mackey, PhD, University of Texas Health Science Center at Houston; EH Page, MD, KF Martinez, MSEE, TA Seitz, MPH, BP Bernard, MD, AL Tepper, PhD, Div of Surveillance, Hazard Evaluations, and Field Studies, National Institute for Occupational Safety and Health; RS Weyant, PhD, Office of Health and Safety; NE Rosenstein, MD, BA Perkins, MD, T Popovic, PhD, Div of Bacterial and Mycotic Diseases; HT Holmes, PhD, Div of Healthcare Quality Promotion, National Center for Infectious Disease; CW Shepard, MD, EIS Officer, CDC.*

Editorial Note: The findings of this investigation indicate that the worker at Laboratory A likely developed cutaneous anthrax because of skin exposure to a contaminated surface. The health hazard evaluation also identified additional steps Laboratory A should take to ensure worker safety.

Because *B. anthracis* can cause lethal infections and can form infectious aerosols, CDC and the National Institutes of Health recommend that laboratories producing quantities or concentrations of *B. anthracis* (i.e., culturing the organism for diagnostic purposes) apply practices appropriate to BSL-3 conditions (*1*). BSL-3 practices emphasize primary and secondary barriers to protect personnel in contiguous areas from exposure to potentially infectious aerosols. A vigorous program of routine decontamination with a 10% bleach solution is needed to kill viable *B. anthracis* spores on laboratory surfaces and vials. Alcohol is not sufficient to eliminate viable *B. anthracis* spores from contaminated surfaces (*2*). Gloves should be used whenever handling material that contains or might contain *B. anthracis*, and skin defects should be covered with an impermeable occlusive bandage while working in the laboratory. Work should be organized so that all *B. anthracis* sample manipulations are performed in a single room with most procedures performed in a BSC. Access to such rooms should be limited to laboratorians directly working with the samples.

The Advisory Committee on Immunization Practices developed guidelines for routine vaccination with anthrax vaccine (*3*). This suspected case of laboratory-acquired cutaneous anthrax highlights the need for anthrax vaccination, in addition to standard laboratory safety procedures, for laboratorians who work routinely with *B. anthracis* specimens.

CDC will work with state and local health departments to identify and vaccinate these laboratory workers.

This case is defined by CDC as a suspected case of cutaneous anthrax rather than a confirmed case (*4*) because processing of the swab of the lesion at the same laboratory where the suspected exposure occurred introduces the possibility of contamination of the patient's sample with *B. anthracis* from the laboratory. However, this patient's clinical syndrome and environmental exposure are consistent with cutaneous anthrax (*4*). CDC will update the surveillance status of this case as the results of other laboratory tests (e.g., serologic tests) become available.

Any exposure leading to a suspected case of cutaneous anthrax requires a public health investigation to identify other exposures in the same setting that might have led to other cases of cutaneous or inhalational anthrax. Local public health authorities should be notified immediately and appropriate laboratory procedures followed when treating clinicians suspect anthrax. This investigation did not identify inhalation exposures, and CDC does not recommend prophylaxis for the prevention of cutaneous anthrax. Active surveillance for cutaneous and inhalational disease should be ongoing among laboratorians working with *B. anthracis*.

Acknowledgment

This report is based on data contributed by D Mattorano, MS, B King, MPH, D Booher, Div of Surveillance, Hazard Evaluations, and Field Studies, National Institute for Occupational Safety and Health, CDC.

References

1. CDC, National Institutes of Health. Biosafety in Microbiological and Biomedical Laboratories. US Department of Health and Human Services, Public Health Service, CDC, National Institutes of Health. 4th ed, May 1999.
2. Rutala WA. APIC guidelines for infection control practice. Am J Infect Control 1996; 24:313–42.
3. CDC. Use of anthrax vaccine in the United States: recommendations of the Advisory Committee of Immunization Practices. MMWR 2000;49(No. RR-15).
4. CDC. Update: investigation of anthrax associated with intentional exposure and interim public health guidelines. MMWR 2001;50:889–93.

Imported Dengue — United States, 1999 and 2000

Dengue is a mosquito-transmitted acute viral illness caused by any of the four dengue virus serotypes (DEN-1, DEN-2, DEN-3, and DEN-4). Dengue is endemic in most tropical and subtropical areas of the world and has occurred among U.S. residents returning from travel to such areas. CDC maintains a laboratory-based passive surveillance system for imported dengue among U.S. residents (laboratory-diagnosed dengue in a U.S. resident living in an area without known authochthonous dengue transmission, with travel history outside the United States in the 14 days before symptom onset). The system relies on reports by clinicians to state health departments, which forward patient specimens to CDC for diagnostic testing. This report summarizes information about imported dengue cases among U.S. residents during 1999–2000. The findings indicate that dengue continues to cause disease in U.S. travelers abroad. Travelers to tropical areas should protect themselves from mosquito bites, and health-care providers should consider dengue in the differential diagnosis of illness for patients who have returned recently from such areas.

Serum samples from 216 persons who had suspected dengue on the basis of clinical presentation and onset of symptoms in 1999 and 2000 were submitted to CDC from 34 states and the District of Columbia (*1*). From these samples, 41 (19%) cases were laboratory-diagnosed as dengue, of which 38 (93%) had IgM antibody or single high titers of IgG antibody in serum samples, and three (7%) patients had isolation of dengue virus (DEN-2, DEN-3, and DEN-4; one case each) (Table 1). Dengue diagnosis was negative in 112 (52%) patients, and indeterminate among 63 (29%) patients because convalescent samples for serologic testing were unavailable.

Of the 40 laboratory-diagnosed dengue cases with available data, 22 (55%) were males. Age was reported for 35 persons (median: 37 years, range: 5–72 years). Clinical information was available for 28 patients with laboratory-diagnosed dengue. The most commonly reported symptoms were fever (100%), headache (64%), rash (54%), and myalgia (39%). At least three patients were identified as having been hospitalized, and one of these died (a male aged 41 years who had recently returned from Bangladesh).

States reporting the highest number of cases were Massachusetts (four) in 1999 and New York (five) in 2000. Travel histories within the 2 weeks before illness, available for 33 persons, indicated that infections probably were acquired in Asia (13 cases), the Caribbean islands (12), Central America (seven), South America (one), and Africa (one). One patient reported traveling both in the Caribbean islands and South America.

Data for both 1999 and 2000 indicated a marked decline in persons tested and in the percentage of persons laboratory-diagnosed with dengue, compared with 1997 and 1998, when 349 persons were tested and 143 (41%) were laboratory-diagnosed with dengue (*2*).

Reported by: *GG Clark, PhD, JG Rigau-Pérez, MD, V Vorndam, PhD, Div of Vector-Borne Infectious Diseases, National Center for Infectious Diseases; JM Hayes, DrPH, EIS Officer, CDC.*

TABLE 1. Suspected and laboratory-diagnosed cases of imported dengue, by state — United States, 1999 and 2000

State	1999 Cases*			2000 Cases		
	Suspected	Laboratory-diagnosed	Travel history, if known, of persons with laboratory-diagnosed dengue (serotype, if known)	Suspected	Laboratory-diagnosed	Travel history, if known, of persons with laboratory-diagnosed dengue (serotype, if known)
Alabama	1			1		
Alaska	2	1	Panama	1		
Arizona	2	2	Panama (two cases)	4	1	Dominican Republic
California	3	1	Nicaragua			
Colorado	5			3		
Connecticut	2	2	Vietnam and Thailand (one case both countries)			
District of Columbia	5			7	1	Niger
Florida	1			5	1	Puerto Rico (DEN-2)
Georgia	4			6		
Hawaii				2	1	Philippines
Illinois				3	1	El Salvador
Iowa				1		
Kansas	1					
Kentucky	1					
Louisiana	1			1		
Maryland	4			5		
Massachusetts	18	4	Jamaica; Haiti (two cases, one DEN-3)	17	3	Bangladesh, Thailand, India
Michigan	4			3		
Minnesota				4	2	Haiti
Mississippi	1					
Missouri	2	1	Belize	1		
North Carolina	4	1	Central America	3	1	Antigua and Guyana (one case each)
New Hampshire				14		
New Jersey	1	1	Philippines	1		
New Mexico				1		
New York	18	3	Burma, Vietnam	18	5	Puerto Rico, Dominican Republic, East Timor, Bangladesh
Ohio				1		
Oregon	3	1	Haiti	2	1	
Rhode Island				1	1	Dominican Republic
Tennessee				1		
Texas*	1			1	1	Bangladesh (fatal case)
Vermont	1			1		
Washington	7	2	Thailand (DEN-4), India	2		
Wisconsin	8	1	Haiti	5	2	
Wyoming	1					
Total	**101**	**20**		**115**	**21**	

* Not including 66 (14.3%) laboratory-positive dengue patients out of 462 suspected cases identified in 1999 by the Texas laboratory-based active surveillance system.

Editorial Note: Dengue is transmitted to humans by *Aedes* mosquitoes. The majority of U.S. residents with dengue become infected during travel to tropical areas, although autochthonous transmission of dengue was documented in Texas in 1999 (*3*,*4*), and Hawaii in 2001 (*5*). The 1999 Texas outbreak was limited in scope because environmental factors (e.g., air conditioning) limited contact with *Ae. aegypti* mosquitoes. In Hawaii, the outbreak might have been limited because the vector was *Ae. albopictus*, a less efficient vector for dengue than *Ae. aegypti*, which was not detected in localities where dengue transmission occurred.

The incubation period of dengue has a range of 3–14 days (in the majority of cases, 4–7 days). Dengue virus infection can be asymptomatic or cause illnesses ranging from mild undifferentiated fever to severe disease, including hemorrhagic manifestations and shock (*6*). Dengue hemorrhagic fever (DHF) is characterized by fever, minor or major bleeding phenomena, thrombocytopenia (≤100,000 platelets/mm^3), and evidence of increased vascular permeability (e.g., hemoconcentration [hematocrit increased by ≥20% from baseline], pleural or abdominal effusions, or hypoproteinemia) (*6*). Dengue shock syndrome (DSS) is DHF with signs of circulatory failure, including narrow pulse pressure (≤20 mmHg), hypotension, or shock, and might result in a case fatality rate of approximately 10% (*7*).

During 1993–1998, the number of imported laboratory-diagnosed U.S. cases increased, reflecting the impact of travel and the occurrence of epidemic dengue in 1995 and 1998,

especially in the Caribbean and Central America. The smaller number of laboratory-diagnosed cases of dengue in 1999 and 2000 is temporally associated with a decreased number of cases of dengue/DHF in the Americas (*8*).

The findings in this report are subject to at least two limitations. First, travel histories and clinical information were available only for certain persons with dengue, and they might not be representative of all persons with imported dengue. Second, the number of dengue cases referred to CDC for diagnosis represents a minimum estimate of the actual number of U.S. travelers with dengue fever or DHF/DSS. Diagnostic samples might not have been sent for testing or might have been sent to other laboratories. Because dengue is not nationally reportable, persons with suspected dengue might not be reported. For example, in response to the 1999 documented authochthonous transmission of dengue, Texas implemented a state laboratory-based active surveillance system. Of the 462 patients whose specimens were submitted for testing at the Texas Department of Health (TDH) or other reference laboratories that year, 66 (14.3%) were laboratory-diagnosed as dengue (TDH, surveillance data, cases not included in this report).

Persons traveling to areas where dengue is endemic should avoid exposure to mosquitoes by using repellents, wearing protective clothing, and remaining in well-screened or air-conditioned areas. No vaccine is available for preventing dengue infection. Health-care providers should consider dengue in the differential diagnosis of illness for all patients who have fever and a history of travel to tropical areas within 2 weeks before the onset of symptoms. Supportive measures should be administered, and only acetaminophen is recommended for management of pain and fever. Acetylsalicylic acid (i.e., aspirin) and other nonsteroidal anti-inflammatory agents are contraindicated because of their anticoagulant properties. Dengue patients should be monitored for signs of DHF, especially hypotension, because prompt fluid therapy reduces morbidity and mortality. Acute-phase (0–5 days after onset of symptoms) and convalescent-phase (6–30 days after onset of symptoms) serum samples obtained for viral isolation and diagnosis should be sent through state or territorial health departments to CDC's Dengue Branch, Division of Vector-Borne Infectious Diseases, National Center for Infectious Diseases, 1324 Calle Cañada, San Juan, PR 00920-3860, telephone 787-706-2399, fax 787-706-2496. Serum samples should be accompanied by a summary of clinical and epidemiologic information, including date of onset of disease, date of collection of sample, and a detailed recent travel history.

Acknowledgment

This report is based on data contributed by state health departments.

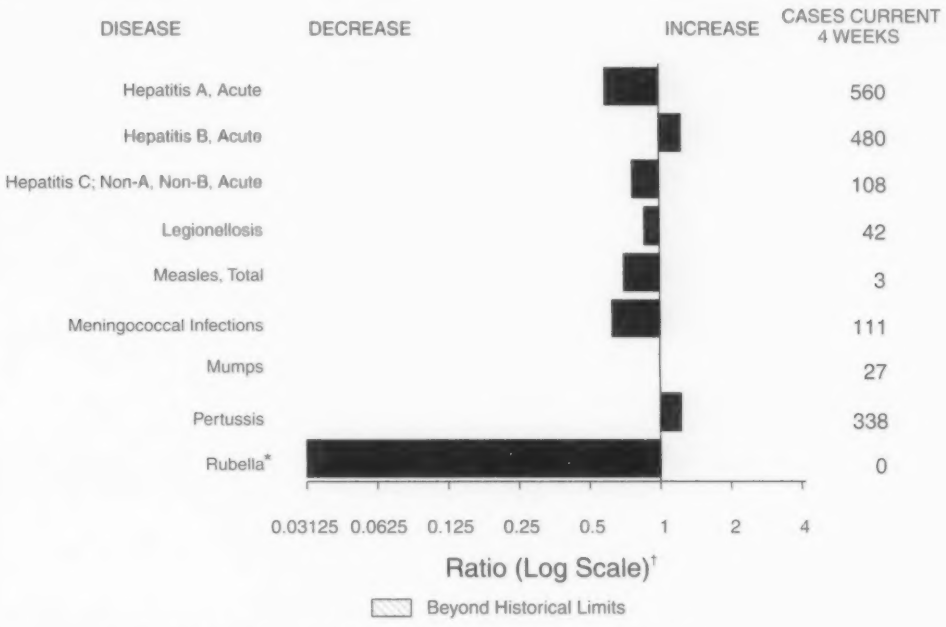
References

1. CDC. Case definitions for infectious conditions under public health surveillance. MMWR 1997;46(No. RR-10):45–6.
2. CDC. Imported dengue—United States, 1997 and 1998. MMWR 2000;49:248–53.
3. Rigau-Pérez JG, Gubler DJ, Vorndam AV, Clark GG. Dengue: a literature review and case study of travelers from the United States, 1986–1994. J Travel Med 1997;4:65–71.
4. CDC. Underdiagnosis of dengue—Laredo, Texas, 1999. MMWR 2001;50:57–59.
5. CDC, National Center for Infectious Diseases, Travelers' Health Notice: Dengue Fever, Hawaii, January 11, 2002. Available at http://www.cdc.gov/travel/other/dengue-hawaii-oct2001.htm.
6. World Health Organization. Dengue haemorrhagic fever: diagnosis, treatment, prevention and control. 2nd ed. Geneva, Switzerland: World Health Organization, 1997.
7. Tassniyom S, Vasanawathana S, Chirawatkul A, Rojanasuphot S. Failure of high-dose methylprednisolone in established dengue shock syndrome: a placebo-controlled, double-blind study. Pediatrics 1993;92:111–5.
8. Pan American Health Organization. Dengue in the Americas: number of reported cases of dengue and dengue hemorrhagic fever (DHF) in the Americas by country, 1997–2000. Available at http://www.paho.org/english/hcp/hct/dengue_1997.htm.

Erratum: Vol 51, No. 12

In the Table II (Cont'd), "Provisional cases of selected notifiable diseases, United States, March 22, 2002 and March 23, 2001 (12th Week)" on page 268, the columns for 2002 and 2001 *Streptococcus pneumoniae*, Invasive (<5 years) inadvertently included cases among persons aged ≥5 years. The corrected year-to-date cumulative counts for *Streptococcus pneumoniae*, Invasive (<5 years) are included in this publication. For corrected incidence data for previous weeks, contact soib@cdc.gov.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals ending March 30, 2002, with historical data



* No rubella cases were reported for the current 4-week period, yielding a ratio for week 13 of zero (0).
† Ratio of current 4-week total to mean of 15 4-week totals (from previous, comparable, and subsequent 4-week periods for the past 5 years). The point where the hatched area begins is based on the mean and two standard deviations of these 4-week totals.

TABLE I. Summary of provisional cases of selected notifiable diseases, United States, cumulative, week ending March 30, 2002 (13th Week)*

		Cum. 2002	Cum. 2001		Cum. 2002	Cum. 2001
Anthrax		1	-	Encephalitis: West Nile†	5	-
Botulism:	foodborne	5	5	Hansen disease (leprosy)†	17	23
	infant	11	25	Hantavirus pulmonary syndrome†	-	2
	other (wound & unspecified)	5	1	Hemolytic uremic syndrome, postdiarrheal†	21	22
Brucellosis†		18	17	HIV infection, pediatric†§	31	49
Chancroid		16	9	Plague	-	-
Cholera		1	-	Poliomyelitis, paralytic	-	-
Cyclosporiasis†		24	36	Psittacosis†	9	3
Diphtheria		-	-	Q fever†	6	2
Ehrlichiosis:	human granulocytic (HGE)†	10	21	Rabies, human	-	-
	human monocytic (HME)†	2	6	Streptococcal toxic-shock syndrome†	10	24
	other and unspecified	-	-	Tetanus	2	6
Encephalitis:	California serogroup viral†	6	1	Toxic-shock syndrome	32	44
	eastern equine†	-	-	Trichinosis	3	5
	Powassan†	-	-	Tularemia†	5	6
	St. Louis†	-	-	Yellow fever	1	-
	western equine†	-	-			

-:No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).
† Not notifiable in all states.
§ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention (NCHSTP). Last update February 24, 2002.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending March 30, 2002, and March 31, 2001 (13th Week)*

Reporting Area	AIDS		Chlamydia†		Cryptosporidiosis		*Escherichia coli*			
							O157:H7		Shiga Toxin Positive, Serogroup non-O157	
	Cum. 2002§	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	10,265	10,393	161,234	186,354	448	429	246	257	14	16
NEW ENGLAND	318	309	5,240	5,657	18	11	20	24	2	6
Maine	1	3	342	311	-	-	-	3	-	-
N.H.	9	12	392	301	3	-	1	3	-	2
Vt.	5	10	183	151	3	5	-	1	-	-
Mass.	178	191	2,728	2,233	3	2	11	15	2	1
R.I.	34	33	684	743	3	2	2	-	-	-
Conn.	91	60	911	1,918	6	2	6	2	-	3
MID. ATLANTIC	2,115	3,267	14,279	19,032	38	61	12	24	-	-
Upstate N.Y.	158	567	1,459	3,099	6	13	8	12	-	-
N.Y. City	1,299	1,870	7,255	7,307	25	29	-	1	-	-
N.J.	387	473	694	2,780	1	2	4	11	-	-
Pa.	271	357	4,871	5,846	6	17	N	N	-	-
E.N. CENTRAL	969	662	25,838	35,982	126	142	82	60	-	-
Ohio	194	99	3,527	9,602	38	26	14	17	-	-
Ind.	133	64	4,171	4,019	13	13	6	9	-	-
Ill.	476	329	7,455	10,632	15	12	21	12	-	-
Mich.	117	137	7,952	7,485	26	29	18	7	-	-
Wis.	49	33	2,733	4,244	34	62	23	15	-	-
W.N. CENTRAL	147	175	7,463	9,729	37	15	34	22	3	1
Minn.	29	35	2,064	2,107	14	-	10	9	3	-
Iowa	34	18	461	954	5	5	9	3	-	-
Mo.	48	72	2,329	3,367	10	6	11	4	-	-
N. Dak.	-	1	154	257	2	-	-	-	-	-
S. Dak.	2	-	541	457	3	1	1	1	-	1
Nebr.	15	25	314	945	-	3	-	-	-	-
Kans.	19	24	1,600	1,642	3	-	3	5	-	-
S. ATLANTIC	3,576	2,972	33,344	35,855	99	83	37	31	7	7
Del.	58	54	619	753	1	-	1	-	-	-
Md.	417	245	3,334	3,718	3	17	-	1	-	-
D.C.	157	233	799	841	2	3	-	-	-	-
Va.	230	263	4,079	4,451	1	5	3	6	-	1
W. Va.	19	17	572	565	1	-	-	1	-	-
N.C.	261	116	5,010	5,383	13	11	6	14	-	-
S.C.	260	214	2,923	4,493	1	1	-	1	-	-
Ga.	650	270	7,230	7,815	47	31	20	4	4	5
Fla.	1,524	1,560	8,778	7,836	30	15	7	4	3	1
E.S. CENTRAL	407	482	12,513	12,676	23	10	5	10	-	-
Ky.	46	74	1,904	2,176	1	1	1	1	-	-
Tenn.	186	160	4,011	3,832	8	2	4	4	-	-
Ala.	85	118	4,252	3,412	13	2	-	4	-	-
Miss.	90	130	2,346	3,256	1	5	-	1	-	-
W.S. CENTRAL	1,062	815	24,958	26,695	5	10	-	28	-	-
Ark.	59	64	1,365	2,060	2	2	-	-	-	-
La.	261	257	4,479	4,406	1	4	-	-	-	-
Okla.	48	44	2,086	2,508	2	1	-	6	-	-
Tex.	694	450	17,028	17,721	-	3	-	22	-	-
MOUNTAIN	317	345	9,376	10,542	30	31	20	17	1	1
Mont.	4	3	524	403	1	1	4	2	-	-
Idaho	6	5	603	472	9	5	1	2	-	-
Wyo.	2	-	200	206	1	-	-	-	1	-
Colo.	64	82	1,137	3,023	8	12	2	4	-	1
N. Mex.	11	30	1,409	1,504	3	6	2	1	-	-
Ariz.	137	123	2,656	3,369	4	1	4	5	-	-
Utah	18	34	1,453	279	2	6	4	2	-	-
Nev.	75	68	1,394	1,286	2	-	3	1	-	-
PACIFIC	1,354	1,366	28,223	30,186	72	66	36	41	1	1
Wash.	147	150	3,455	3,441	15	U	7	8	-	-
Oreg.	129	52	1,751	1,842	8	8	7	2	1	1
Calif.	1,063	1,144	21,265	23,222	49	58	20	27	-	-
Alaska	2	8	858	637	-	-	-	-	-	-
Hawaii	13	12	894	1,044	-	-	2	4	-	-
Guam	-	6	-	-	-	-	N	N	-	-
P.R.	273	326	-	1,120	-	-	-	-	-	-
V.I.	53	1	-	50	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	37	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. -: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.

* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

† Chlamydia refers to genital infections caused by *C. trachomatis*.

§ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention. Last update March 31, 2002.

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending March 30, 2002, and March 31, 2001 (13th Week)*

Reporting Area	*Escherichia coli* Shiga Toxin Positive, Not Serogrouped		Giardiasis	Gonorrhea		*Haemophilus influenzae*, Invasive			
						All Ages, All Serotypes		Age <5 Years Serotype B	
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	1	3	2,727	70,054	85,694	392	422	3	7
NEW ENGLAND	-	-	298	1,544	1,550	32	13	-	1
Maine	-	-	39	16	42	1	1	-	-
N.H.	-	-	14	32	32	4	-	-	-
Vt.	-	-	24	25	23	3	-	-	-
Mass.	-	-	138	931	685	16	12	-	1
R.I.	-	-	18	231	180	-	-	-	-
Conn.	-	-	65	309	588	8	-	-	-
MID. ATLANTIC	-	-	461	6,123	9,030	49	64	1	-
Upstate N.Y.	-	-	94	776	1,793	17	12	1	-
N.Y. City	-	-	249	2,969	3,120	20	18	-	-
N.J.	-	-	-	451	1,274	9	28	-	-
Pa.	-	-	118	1,927	2,843	3	6	-	-
E.N. CENTRAL	1	2	558	12,493	18,193	56	64	1	1
Ohio	1	2	216	2,049	5,089	34	24	-	1
Ind.	-	-	-	1,873	1,721	13	6	-	-
Ill.	-	-	91	4,240	5,558	-	24	-	-
Mich.	-	-	178	3,513	4,337	5	3	1	-
Wis.	-	-	73	818	1,488	4	7	-	-
W.N. CENTRAL	-	-	311	3,337	4,021	12	10	-	-
Minn.	-	-	116	657	673	9	4	-	-
Iowa	-	-	60	134	239	1	-	-	-
Mo.	-	-	86	1,680	1,948	2	6	-	-
N. Dak.	-	-	3	10	8	-	-	-	-
S. Dak.	-	-	16	71	51	-	-	-	-
Nebr.	-	-	-	118	357	-	-	-	-
Kans.	-	-	30	667	745	-	-	-	-
S. ATLANTIC	-	-	507	19,708	22,390	111	138	-	1
Del.	-	-	11	389	410	-	-	-	-
Md.	-	-	25	1,909	2,114	26	33	-	-
D.C.	-	-	11	681	802	-	-	-	-
Va.	-	-	16	2,556	2,386	7	9	-	-
W. Va.	-	-	8	226	124	1	4	-	1
N.C.	-	-	-	3,633	4,415	11	18	-	-
S.C.	-	-	3	1,665	3,459	3	2	-	-
Ga.	-	-	175	3,919	4,290	37	37	-	-
Fla.	-	-	258	4,730	4,390	26	35	-	-
E.S. CENTRAL	-	1	76	7,117	8,116	18	22	1	-
Ky.	-	1	-	759	851	2	1	-	-
Tenn.	-	-	32	2,214	2,521	10	10	-	-
Ala.	-	-	44	2,725	2,764	5	10	1	-
Miss.	-	-	-	1,419	1,980	1	1	-	-
W.S. CENTRAL	-	-	14	11,293	13,095	19	10	-	1
Ark.	-	-	14	873	1,307	1	-	-	-
La.	-	-	-	2,857	3,014	-	2	-	-
Okla.	-	-	-	936	1,195	18	7	-	-
Tex.	-	-	-	6,627	7,579	-	1	-	1
MOUNTAIN	-	-	284	2,346	2,557	54	66	-	2
Mont.	-	-	15	32	20	-	-	-	-
Idaho	-	-	8	26	24	1	1	-	-
Wyo.	-	-	2	16	16	1	-	-	-
Colo.	-	-	101	766	839	13	11	-	-
N. Mex.	-	-	32	267	259	13	10	-	-
Ariz.	-	-	46	694	911	18	36	-	1
Utah	-	-	47	108	26	6	1	-	-
Nev.	-	-	33	437	462	2	7	-	1
PACIFIC	-	-	218	6,093	6,742	41	35	-	1
Wash.	-	-	59	767	769	-	1	-	-
Oreg.	-	-	110	239	317	25	4	-	-
Calif.	-	-	-	4,814	5,410	6	16	-	1
Alaska	-	-	20	152	79	1	1	-	-
Hawaii	-	-	29	121	167	9	13	-	-
Guam	-	-	-	-	-	-	-	-	-
P.R.	-	-	-	-	286	-	-	-	-
V.I.	-	-	-	-	6	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	3	U	-	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending March 30, 2002, and March 31, 2001 (13th Week)*

Reporting Area	*Haemophilus influenzae*, Invasive, Age <5 Years, Non-Serotype B, Cum. 2002	Non-Serotype B, Cum. 2001	Unknown Serotype, Cum. 2002	Unknown Serotype, Cum. 2001	Hepatitis (Viral, Acute), By Type, A, Cum. 2002	A, Cum. 2001	B, Cum. 2002	B, Cum. 2001	C; Non-A, Non-B, Cum. 2002	C; Non-A, Non-B, Cum. 2001
UNITED STATES	66	76	4	7	2,031	3,120	1,375	1,722	358	1,262
NEW ENGLAND	5	4	-	-	90	102	34	28	4	19
Maine	-	-	-	-	4	1	1	1	-	-
N.H.	-	-	-	-	5	2	5	3	-	-
Vt.	-	-	-	-	-	2	2	1	4	5
Mass.	3	4	-	-	45	39	25	4	-	14
R.I.	-	-	-	-	4	4	1	6	-	-
Conn.	2	-	-	-	32	54	-	13	-	-
MID. ATLANTIC	8	11	-	-	222	346	288	368	101	605
Upstate N.Y.	4	-	-	-	17	52	13	27	4	8
N.Y. City	3	4	-	-	114	100	175	154	-	-
N.J.	1	3	-	-	34	146	50	123	94	580
Pa.	-	4	-	-	57	48	50	64	3	17
E.N. CENTRAL	7	13	-	-	248	709	222	167	29	79
Ohio	3	3	-	-	86	70	29	31	4	4
Ind.	4	1	-	-	13	24	6	4	-	-
Ill.	-	7	-	-	74	492	20	13	3	20
Mich.	-	-	-	-	59	99	167	119	22	55
Wis.	-	2	-	-	16	24	-	-	-	-
W.N. CENTRAL	1	1	2	1	90	123	49	55	108	311
Minn.	1	1	1	-	11	7	2	4	-	-
Iowa	-	-	-	-	24	10	6	5	1	-
Mo.	-	-	1	1	18	39	34	34	107	309
N. Dak.	-	-	-	-	-	-	-	-	-	-
S. Dak.	-	-	-	-	2	1	-	1	-	-
Nebr.	-	-	-	-	-	17	-	5	-	1
Kans.	-	-	-	-	35	49	7	6	-	1
S. ATLANTIC	17	23	-	3	641	513	366	384	35	25
Del.	-	-	-	-	2	2	1	4	3	1
Md.	-	2	-	-	84	63	33	36	5	6
D.C.	-	-	-	-	24	12	4	3	-	-
Va.	2	4	-	-	11	35	26	29	-	-
W. Va.	-	-	-	-	6	1	7	3	-	-
N.C.	1	1	-	3	90	30	46	51	6	6
S.C.	1	-	-	-	13	13	9	1	3	2
Ga.	7	10	-	-	123	220	144	181	2	1
Fla.	6	6	-	-	288	137	96	76	16	9
E.S. CENTRAL	4	3	-	1	45	74	37	105	34	20
Ky.	-	-	-	-	21	10	10	15	1	1
Tenn.	2	1	-	-	-	35	-	37	10	14
Ala.	2	1	-	1	8	24	14	28	2	1
Miss.	-	1	-	-	16	5	13	25	21	4
W.S. CENTRAL	4	1	-	-	28	523	94	201	2	155
Ark.	-	-	-	-	11	16	26	22	-	2
La.	-	-	-	-	5	25	5	28	2	71
Okla.	4	1	-	-	11	48	1	23	-	1
Tex.	-	-	-	-	1	434	62	128	-	81
MOUNTAIN	12	8	1	1	166	222	96	121	17	18
Mont.	-	-	-	-	5	4	2	1	-	-
Idaho	-	-	-	-	-	24	-	4	-	1
Wyo.	-	-	-	-	3	1	6	-	4	2
Colo.	2	-	-	-	28	26	22	26	9	5
N. Mex.	4	4	-	1	4	7	11	32	-	6
Ariz.	4	4	-	-	91	112	39	42	-	1
Utah	1	-	-	-	15	18	7	4	-	-
Nev.	1	-	1	-	20	30	9	12	4	3
PACIFIC	8	12	1	1	501	508	189	293	28	30
Wash.	-	-	-	1	38	19	11	19	3	9
Oreg.	4	-	-	-	31	8	33	8	7	1
Calif.	3	11	1	-	426	470	141	256	18	20
Alaska	1	-	-	-	6	10	2	3	-	-
Hawaii	-	1	-	-	-	1	2	7	-	-
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	-	-	-	-	19	28	13	51	-	1
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	4	U	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending March 30, 2002, and March 31, 2001 (13th Week)*

Reporting Area	Legionellosis		Listeriosis		Lyme Disease		Malaria		Measles Total	
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	141	197	81	104	597	1,045	220	281	3[†]	53[§]
NEW ENGLAND	6	5	9	9	46	165	13	23	-	4
Maine	1	-	2	-	-	-	1	1	-	-
N.H.	1	-	2	-	13	2	4	1	-	-
Vt.	-	2	-	-	1	1	-	-	-	1
Mass.	2	2	3	6	29	52	3	11	-	3
R.I.	-	-	-	-	3	-	-	-	-	-
Conn.	2	1	2	3	-	110	5	10	-	-
MID. ATLANTIC	20	47	12	18	412	704	40	72	-	5
Upstate N.Y.	1	9	6	3	227	182	4	9	-	4
N.Y. City	6	3	3	4	22	9	26	39	-	-
N.J.	1	8	-	8	28	124	6	16	-	-
Pa.	12	27	3	3	135	389	4	8	-	1
E.N. CENTRAL	50	57	12	13	8	27	26	46	-	7
Ohio	30	22	7	1	7	4	7	5	-	2
Ind.	3	4	-	1	1	-	1	8	-	2
Ill.	-	8	-	4	-	3	4	13	-	3
Mich.	14	14	3	5	-	-	11	13	-	-
Wis.	3	9	2	2	U	20	3	7	-	-
W.N. CENTRAL	6	11	2	2	10	15	17	6	2	3
Minn.	1	1	-	-	3	10	7	1	2	1
Iowa	-	2	-	-	3	1	2	1	-	-
Mo.	4	5	1	1	4	3	5	3	-	2
N. Dak.	-	-	1	-	-	-	-	-	-	-
S. Dak.	1	-	-	-	-	-	-	-	-	-
Nebr.	-	2	-	-	-	-	-	-	-	-
Kans.	-	1	-	1	-	1	3	1	-	-
S. ATLANTIC	31	24	12	14	86	92	78	63	1	3
Del.	3	-	-	-	5	6	1	1	-	-
Md.	4	6	2	2	45	74	19	23	-	3
D.C.	-	1	-	-	5	5	2	4	-	-
Va.	2	4	1	2	-	4	4	11	-	-
W. Va.	N	N	-	1	-	1	-	-	-	-
N.C.	3	2	1	-	11	2	6	1	-	-
S.C.	3	-	2	-	1	-	2	2	-	-
Ga.	3	2	3	3	-	-	33	10	-	-
Fla.	13	9	3	6	19	-	11	11	1	-
E.S. CENTRAL	5	18	5	6	2	2	3	8	-	-
Ky.	3	5	1	1	1	2	-	2	-	-
Tenn.	-	6	2	3	1	-	1	3	-	-
Ala.	2	3	2	2	-	-	1	3	-	-
Miss.	-	4	-	-	-	-	1	-	-	-
W.S. CENTRAL	-	3	3	9	2	22	2	3	-	1
Ark.	-	-	-	1	-	-	-	-	-	-
La.	-	2	-	-	1	1	2	1	-	-
Okla.	-	-	3	-	-	-	-	1	-	-
Tex.	-	1	-	8	1	21	-	1	-	1
MOUNTAIN	11	9	8	7	5	1	8	17	-	1
Mont.	1	-	-	-	-	-	-	1	-	-
Idaho	-	-	-	-	-	-	-	1	-	1
Wyo.	3	1	-	-	-	-	-	-	-	-
Colo.	4	3	2	1	2	-	3	9	-	-
N. Mex.	1	1	-	2	1	-	-	1	-	-
Ariz.	-	3	4	1	1	-	2	1	-	-
Utah	2	-	2	1	1	-	2	2	-	-
Nev.	-	1	-	2	-	1	1	2	-	-
PACIFIC	12	23	18	26	26	17	33	43	-	29
Wash.	1	5	1	1	-	1	2	1	-	15
Oreg.	N	N	1	3	1	1	-	2	-	2
Calif.	11	16	16	22	25	15	28	37	-	10
Alaska	-	1	-	-	-	-	1	1	-	-
Hawaii	-	1	-	-	N	N	2	2	-	2
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	-	2	-	-	N	N	-	1	-	-
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).
† Of three cases reported, two were indigenous and one was imported from another country.
§ Of 53 cases reported, 28 were indigenous and 25 were imported from another country.

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending March 30, 2002, and March 31, 2001 (13th Week)*

Reporting Area	Meningococcal Disease		Mumps		Pertussis		Rabies, Animal	
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	417	886	72	42	1,067	1,370	866	1,405
NEW ENGLAND	35	48	4	-	178	158	164	122
Maine	2	-	-	-	3	-	12	17
N.H.	4	3	3	-	1	16	2	2
Vt.	3	4	-	-	30	22	33	25
Mass.	19	28	1	-	144	114	53	33
R.I.	2	1	-	-	-	-	4	12
Conn.	5	12	-	-	-	6	60	33
MID. ATLANTIC	30	105	9	2	43	100	52	81
Upstate N.Y.	6	26	1	1	21	60	28	-
N.Y. City	4	19	1	1	5	10	7	1
N.J.	6	40	1	-	-	2	-	28
Pa.	14	20	6	-	17	28	17	52
E.N. CENTRAL	58	98	9	5	180	152	3	8
Ohio	27	28	4	1	114	100	1	-
Ind.	11	1	-	-	14	5	1	1
Ill.	-	28	2	4	23	10	1	-
Mich.	14	25	3	-	21	17	-	3
Wis.	6	16	-	-	8	20	-	4
W.N. CENTRAL	39	47	6	1	146	41	75	81
Minn.	7	1	-	-	46	-	7	14
Iowa	5	11	-	-	46	7	9	13
Mo.	21	21	3	-	35	21	2	5
N. Dak.	-	2	-	-	-	-	-	12
S. Dak.	2	2	-	-	5	2	16	13
Nebr.	-	2	-	-	-	1	-	-
Kans.	4	8	3	1	14	10	41	24
S. ATLANTIC	84	155	11	4	83	60	424	491
Del.	3	-	-	-	1	-	3	10
Md.	2	20	2	2	12	10	45	88
D.C.	-	-	-	-	-	-	-	-
Va.	8	16	2	1	21	6	133	90
W. Va.	-	4	-	-	1	1	35	35
N.C.	11	36	1	-	11	23	132	134
S.C.	10	12	1	1	18	7	17	23
Ga.	12	26	2	-	10	7	59	68
Fla.	38	41	3	-	9	6	-	43
E.S. CENTRAL	21	52	4	-	40	26	33	115
Ky.	3	8	1	-	14	9	6	5
Tenn.	7	17	1	-	23	11	21	106
Ala.	9	20	1	-	3	3	6	4
Miss.	2	7	1	-	-	3	-	-
W.S. CENTRAL	17	192	4	5	101	54	25	358
Ark.	7	7	-	1	5	4	-	-
La.	3	36	-	2	-	1	-	2
Okla.	6	13	-	-	12	2	25	19
Tex.	1	136	4	2	84	47	-	337
MOUNTAIN	37	39	3	4	149	588	35	55
Mont.	1	-	-	-	2	3	3	5
Idaho	-	3	1	-	21	146	-	-
Wyo.	-	-	-	1	3	-	1	15
Colo.	12	15	-	1	81	126	-	-
N. Mex.	1	6	-	2	22	37	-	1
Ariz.	12	7	-	-	10	266	31	34
Utah	4	5	2	-	8	9	-	-
Nev.	7	3	-	-	2	1	-	-
PACIFIC	96	150	22	21	147	191	55	94
Wash.	15	22	-	-	79	25	-	-
Oreg.	17	5	N	N	14	3	-	-
Calif.	60	116	18	12	49	154	34	64
Alaska	1	1	-	1	2	-	21	30
Hawaii	3	6	4	8	3	9	-	-
Guam	-	-	-	-	-	-	-	-
P.R.	1	1	-	-	-	1	16	27
V.I.	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending March 30, 2002, and March 31, 2001 (13th Week)*

Reporting Area	Rocky Mountain Spotted Fever		Rubella				Salmonellosis	
			Rubella		Congenital Rubella			
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	68	21	-	5	1	-	5,323	6,047
NEW ENGLAND	-	-	-	-	-	-	309	403
Maine	-	-	-	-	-	-	44	21
N.H.	-	-	-	-	-	-	13	26
Vt.	-	-	-	-	-	-	14	20
Mass.	-	-	-	-	-	-	167	254
R.I.	-	-	-	-	-	-	5	21
Conn.	-	-	-	-	-	-	66	61
MID. ATLANTIC	5	1	-	3	-	-	515	950
Upstate N.Y.	-	-	-	1	-	-	94	158
N.Y. City	-	-	-	2	-	-	234	215
N.J.	-	-	-	-	-	-	57	351
Pa.	5	1	-	-	-	-	130	226
E.N. CENTRAL	3	2	-	1	-	-	936	829
Ohio	3	-	-	-	-	-	298	248
Ind.	-	1	-	-	-	-	50	58
Ill.	-	1	-	1	-	-	300	245
Mich.	-	-	-	-	-	-	190	146
Wis.	-	-	-	-	-	-	98	132
W.N. CENTRAL	10	3	-	-	-	-	421	352
Minn.	-	-	-	-	-	-	77	114
Iowa	-	-	-	-	-	-	63	51
Mo.	10	3	-	-	-	-	204	86
N. Dak.	-	-	-	-	-	-	5	1
S. Dak.	-	-	-	-	-	-	20	22
Nebr.	-	-	-	-	-	-	-	30
Kans.	-	-	-	-	-	-	52	48
S. ATLANTIC	46	11	-	-	-	-	1,441	1,357
Del.	-	-	-	-	-	-	11	16
Md.	5	2	-	-	-	-	126	137
D.C.	-	-	-	-	-	-	19	16
Va.	1	-	-	-	-	-	91	136
W. Va.	-	-	-	-	-	-	8	9
N.C.	30	6	-	-	-	-	223	233
S.C.	5	1	-	-	-	-	68	129
Ga.	4	-	-	-	-	-	377	369
Fla.	1	2	-	-	-	-	518	312
E.S. CENTRAL	4	3	-	-	-	-	305	326
Ky.	-	-	-	-	-	-	44	58
Tenn.	4	2	-	-	-	-	100	82
Ala.	-	1	-	-	-	-	102	125
Miss.	-	-	-	-	-	-	59	61
W.S. CENTRAL	-	-	-	-	-	-	117	644
Ark.	-	-	-	-	-	-	49	52
La.	-	-	-	-	-	-	8	142
Okla.	-	-	-	-	-	-	58	26
Tex.	-	-	-	-	-	-	2	424
MOUNTAIN	-	1	-	-	-	-	391	352
Mont.	-	-	-	-	-	-	10	12
Idaho	-	1	-	-	-	-	21	17
Wyo.	-	-	-	-	-	-	11	15
Colo.	-	-	-	-	-	-	109	96
N. Mex.	-	-	-	-	-	-	59	43
Ariz.	-	-	-	-	-	-	100	109
Utah	-	-	-	-	-	-	36	38
Nev.	-	-	-	-	-	-	45	22
PACIFIC	-	-	-	1	1	-	888	834
Wash.	-	-	-	-	-	-	41	76
Oreg.	-	-	-	-	-	-	62	17
Calif.	-	-	-	-	-	-	725	655
Alaska	-	-	-	-	-	-	14	10
Hawaii	-	-	-	1	1	-	46	76
Guam	-	-	-	-	-	-	-	-
P.R.	-	-	-	-	-	-	37	184
V.I.	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	2	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending March 30, 2002, and March 31, 2001 (13th Week)*

Reporting Area	Shigellosis		Streptococcal Disease, Invasive, Group A		*Streptococcus pneumoniae*, Drug Resistant, Invasive		*Streptococcus pneumoniae*, Invasive (<5 Years)	
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	2,752	3,112	933	1,144	699	953	27	38
NEW ENGLAND	54	48	48	41	1	4	1	1
Maine	2	1	13	7	-	-	-	-
N.H.	3	-	16	4	-	-	-	-
Vt.	-	-	1	6	1	4	1	-
Mass.	41	36	18	22	-	-	-	-
R.I.	-	2	-	2	-	-	-	1
Conn.	8	9	-	-	-	-	-	-
MID. ATLANTIC	113	399	105	190	8	47	5	31
Upstate N.Y.	16	107	36	68	8	46	5	31
N.Y. City	67	105	34	70	U	U	-	-
N.J.	6	118	22	46	-	-	-	-
Pa.	24	69	13	6	-	1	-	-
E.N. CENTRAL	379	449	151	270	47	56	10	5
Ohio	237	106	59	67	-	-	1	-
Ind.	14	64	7	1	47	56	9	5
Ill.	66	143	1	101	-	-	-	-
Mich.	42	86	84	83	-	-	-	-
Wis.	20	50	-	18	-	-	-	-
W.N. CENTRAL	239	337	71	75	165	13	9	1
Minn.	31	143	34	11	120	-	9	-
Iowa	26	56	-	-	-	-	-	-
Mo.	36	65	21	26	4	5	-	-
N. Dak.	-	9	-	2	-	1	-	1
S. Dak.	111	15	3	2	1	-	-	-
Nebr.	-	21	-	9	-	3	-	-
Kans.	35	28	13	25	40	4	-	-
S. ATLANTIC	1,150	444	200	236	402	677	2	-
Del.	3	3	-	1	3	-	-	-
Md.	131	29	25	17	-	-	-	-
D.C.	15	14	3	-	26	2	1	-
Va.	205	28	14	44	-	-	-	-
W. Va.	2	4	-	8	11	14	-	-
N.C.	65	98	50	35	-	-	-	-
S.C.	11	28	13	2	54	105	1	-
Ga.	480	99	54	89	107	271	-	-
Fla.	238	141	41	40	201	285	-	-
E.S. CENTRAL	214	234	39	28	52	98	-	-
Ky.	43	83	5	13	5	10	-	-
Tenn.	15	20	34	15	47	87	-	-
Ala.	91	54	-	-	-	1	-	-
Miss.	65	77	-	-	-	-	-	-
W.S. CENTRAL	90	572	12	128	7	41	-	-
Ark.	24	125	-	-	2	10	-	-
La.	8	56	-	-	5	31	-	-
Okla.	57	3	11	20	-	-	-	-
Tex.	1	388	1	108	-	-	-	-
MOUNTAIN	107	164	145	114	17	16	-	-
Mont.	-	-	-	-	-	-	-	-
Idaho	2	5	1	2	-	-	-	-
Wyo.	1	-	3	1	7	-	-	-
Colo.	28	31	83	57	-	-	-	-
N. Mex.	15	33	34	28	9	16	-	-
Ariz.	45	74	24	24	1	-	-	-
Utah	9	8	-	2	-	-	-	-
Nev.	7	13	-	-	-	-	-	-
PACIFIC	406	465	162	62	-	1	-	-
Wash.	15	43	26	-	-	-	-	-
Oreg.	30	6	-	-	-	-	-	-
Calif.	346	403	120	47	-	-	-	-
Alaska	1	2	-	-	-	-	-	-
Hawaii	14	11	16	15	-	1	-	-
Guam	-	-	-	-	-	-	-	-
P.R.	1	6	-	-	-	-	-	-
V.I.	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	-	-	U	U
C.N.M.I.	-	U	-	U	-	-	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
*Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending March 30, 2002, and March 31, 2001 (13th Week)*

Reporting Area	Syphilis: Primary & Secondary Cum. 2002	Syphilis: Primary & Secondary Cum. 2001	Syphilis: Congenital† Cum. 2002	Syphilis: Congenital† Cum. 2001	Tuberculosis Cum. 2002	Tuberculosis Cum. 2001	Typhoid Fever Cum. 2002	Typhoid Fever Cum. 2001
UNITED STATES	1,332	1,341	2	116	1,597	2,455	51	69
NEW ENGLAND	17	9	-	1	64	78	5	4
Maine	-	-	-	-	-	-	-	-
N.H.	-	-	-	-	3	6	-	-
Vt.	-	-	-	-	-	2	-	-
Mass.	12	6	-	1	29	42	4	4
R.I.	2	-	-	-	11	6	-	-
Conn.	3	3	-	-	21	22	1	-
MID. ATLANTIC	132	108	-	18	329	368	13	26
Upstate N.Y.	2	4	-	12	26	-	2	4
N.Y. City	81	64	-	-	235	209	8	3
N.J.	30	18	-	5	11	100	3	19
Pa.	19	22	-	1	57	59	-	-
E.N. CENTRAL	265	195	-	20	214	234	8	4
Ohio	37	16	-	1	40	49	3	1
Ind.	12	44	-	3	22	21	1	-
Ill.	66	71	-	14	102	113	-	1
Mich.	145	57	-	2	44	33	3	1
Wis.	5	7	-	-	6	18	1	1
W.N. CENTRAL	12	21	-	3	88	88	1	4
Minn.	3	11	-	-	46	46	-	-
Iowa	-	-	-	-	-	9	-	-
Mo.	4	5	-	1	34	22	1	4
N. Dak.	-	-	-	-	-	-	-	-
S. Dak.	-	-	-	-	5	1	-	-
Nebr.	3	-	-	-	-	10	-	-
Kans.	2	5	-	2	3	-	-	-
S. ATLANTIC	351	506	-	29	336	476	9	10
Del.	4	3	-	-	-	-	-	-
Md.	29	69	-	1	33	35	1	3
D.C.	18	9	-	1	-	20	-	-
Va.	8	38	-	-	15	51	-	1
W. Va.	-	-	-	-	7	8	-	-
N.C.	84	124	-	2	49	53	-	1
S.C.	29	76	-	8	27	37	-	-
Ga.	49	65	-	6	42	85	5	3
Fla.	130	122	-	11	163	187	3	2
E.S. CENTRAL	158	144	-	7	147	170	-	-
Ky.	15	12	-	-	26	17	-	-
Tenn.	64	76	-	4	66	58	-	-
Ala.	60	26	-	2	45	67	-	-
Miss.	19	30	-	1	10	28	-	-
W.S. CENTRAL	178	177	2	20	52	386	-	4
Ark.	6	12	-	2	19	33	-	-
La.	34	37	-	-	-	-	-	-
Okla.	14	23	-	1	33	13	-	-
Tex.	124	105	2	17	-	340	-	4
MOUNTAIN	59	48	-	5	42	95	3	2
Mont.	-	-	-	-	-	-	-	1
Idaho	1	-	-	-	-	4	-	-
Wyo.	-	-	-	-	1	-	-	-
Colo.	-	4	-	-	10	26	2	-
N. Mex.	9	4	-	-	7	10	-	-
Ariz.	43	32	-	5	17	29	-	-
Utah	5	6	-	-	5	5	1	-
Nev.	1	2	-	-	2	21	-	1
PACIFIC	160	133	-	13	325	560	12	15
Wash.	13	19	-	-	55	38	-	1
Oreg.	4	3	-	-	19	19	2	-
Calif.	142	108	-	13	204	452	10	13
Alaska	-	-	-	-	19	13	-	-
Hawaii	1	3	-	-	28	38	-	1
Guam	-	-	-	-	-	-	-	-
P.R.	-	111	-	4	-	23	-	-
V.I.	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	2	U	-	U	11	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).
† Updated from reports to the Division of STD Prevention, NCHSTP.

TABLE III. Deaths in 122 U.S. cities,* week ending March 30, 2002 (13th Week)

Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	544	399	85	36	14	10	55
Boston, Mass.	136	88	27	13	2	6	15
Bridgeport, Conn.	U	U	U	U	U	U	U
Cambridge, Mass.	9	6	2	1	-	-	1
Fall River, Mass.	20	19	1	-	-	-	2
Hartford, Conn.	U	U	U	U	U	U	U
Lowell, Mass.	24	19	4	-	1	-	1
Lynn, Mass.	14	8	4	2	-	-	-
New Bedford, Mass.	41	37	4	-	-	-	1
New Haven, Conn.	37	30	5	2	-	-	8
Providence, R.I.	117	90	15	4	6	2	11
Somerville, Mass.	7	6	1	-	-	-	-
Springfield, Mass.	47	33	4	4	4	2	5
Waterbury, Conn.	28	22	4	1	1	-	3
Worcester, Mass.	64	41	14	9	-	-	8
MID. ATLANTIC	2,306	1,688	404	125	37	51	169
Albany, N.Y.	54	41	9	1	-	3	5
Allentown, Pa.	16	14	1	1	-	-	-
Buffalo, N.Y.	99	78	13	4	2	2	11
Camden, N.J.	53	28	12	5	1	7	3
Elizabeth, N.J.	20	16	4	-	-	-	1
Erie, Pa.	46	32	8	4	-	2	8
Jersey City, N.J.	34	24	6	4	-	-	-
New York City, N.Y.	1,130	823	200	77	13	17	49
Newark, N.J.	27	14	7	3	2	1	4
Paterson, N.J.	16	8	6	1	1	-	3
Philadelphia, Pa.	362	248	72	15	12	14	22
Pittsburgh, Pa.§	22	15	6	-	-	1	1
Reading, Pa.	26	20	6	-	-	-	5
Rochester, N.Y.	147	116	26	5	-	-	12
Schenectady, N.Y.	26	17	6	2	1	-	5
Scranton, Pa.	34	25	4	-	4	1	1
Syracuse, N.Y.	141	125	11	3	-	2	31
Trenton, N.J.	36	30	4	-	1	1	7
Utica, N.Y.	17	14	3	-	-	-	1
Yonkers, N.Y.	U	U	U	U	U	U	U
E.N. CENTRAL	1,608	1,136	334	87	24	27	131
Akron, Ohio	67	45	15	2	2	3	6
Canton, Ohio	41	34	5	1	-	1	5
Chicago, Ill.	U	U	U	U	U	U	U
Cincinnati, Ohio	U	U	U	U	U	U	U
Cleveland, Ohio	114	76	28	9	-	1	3
Columbus, Ohio	197	127	55	10	2	3	16
Dayton, Ohio	117	89	19	6	2	1	12
Detroit, Mich.	184	99	51	22	8	4	12
Evansville, Ind.	51	40	8	3	-	-	7
Fort Wayne, Ind.	88	73	11	2	2	-	8
Gary, Ind.	15	11	2	2	-	-	2
Grand Rapids, Mich.	49	37	6	4	1	1	4
Indianapolis, Ind.	172	121	43	5	1	2	15
Lansing, Mich.	46	36	6	3	-	1	4
Milwaukee, Wis.	109	83	20	2	1	3	9
Peoria, Ill.	73	53	13	4	2	1	6
Rockford, Ill.	58	42	14	2	-	-	2
South Bend, Ind.	47	35	7	4	-	1	5
Toledo, Ohio	115	85	21	4	-	5	14
Youngstown, Ohio	65	50	10	2	3	-	1
W.N. CENTRAL	801	549	158	51	23	20	79
Des Moines, Iowa	170	129	34	3	2	2	19
Duluth, Minn.	33	28	3	2	-	-	1
Kansas City, Kans.	43	25	12	2	3	1	7
Kansas City, Mo.	123	80	23	10	5	5	11
Lincoln, Nebr.	32	23	6	1	-	2	3
Minneapolis, Minn.	86	52	18	10	4	2	8
Omaha, Nebr.	72	51	16	2	2	1	11
St. Louis, Mo.	106	68	19	8	5	6	6
St. Paul, Minn.	40	28	10	2	-	-	4
Wichita, Kans.	96	65	17	11	2	1	9
S. ATLANTIC	1,397	862	335	131	40	28	121
Atlanta, Ga.	167	96	47	20	3	1	10
Baltimore, Md.	239	143	61	21	6	8	32
Charlotte, N.C.	105	69	26	8	2	-	16
Jacksonville, Fla.	143	89	41	9	4	-	11
Miami, Fla.	101	58	17	22	2	2	12
Norfolk, Va.	53	42	6	3	1	1	3
Richmond, Va.	64	36	16	8	3	1	9
Savannah, Ga.	56	33	14	3	3	3	6
St. Petersburg, Fla.	55	42	5	6	1	1	6
Tampa, Fla.	203	139	35	16	8	5	12
Washington, D.C.	201	113	59	15	7	6	4
Wilmington, Del.	10	2	8	-	-	-	-
E.S. CENTRAL	960	652	202	63	21	22	104
Birmingham, Ala.	218	146	46	13	8	5	25
Chattanooga, Tenn.	57	37	16	1	-	3	4
Knoxville, Tenn.	94	69	18	6	1	-	5
Lexington, Ky.	78	51	16	4	3	4	13
Memphis, Tenn.	173	125	28	16	1	3	19
Mobile, Ala.	126	85	26	9	2	4	7
Montgomery, Ala.	69	44	15	8	1	1	8
Nashville, Tenn.	145	95	37	6	5	2	23
W.S. CENTRAL	1,510	974	322	112	61	40	115
Austin, Tex.	87	45	24	9	3	6	8
Baton Rouge, La.	54	41	8	1	4	-	2
Corpus Christi, Tex.	51	39	7	2	2	1	5
Dallas, Tex.	219	108	72	24	9	6	9
El Paso, Tex.	42	31	8	1	2	-	3
Ft. Worth, Tex.	136	93	22	11	2	8	13
Houston, Tex.	377	236	75	32	23	10	26
Little Rock, Ark.	64	43	13	4	1	3	3
New Orleans, La.	48	30	8	3	7	-	-
San Antonio, Tex.	235	167	47	15	4	2	19
Shreveport, La.	82	53	17	6	3	3	11
Tulsa, Okla.	115	88	21	4	1	1	16
MOUNTAIN	1,100	738	230	74	34	24	93
Albuquerque, N.M.	110	72	24	9	5	-	9
Boise, Idaho	36	28	5	1	-	2	3
Colo. Springs, Colo.	79	50	19	5	3	2	7
Denver, Colo.	123	80	27	7	5	4	12
Las Vegas, Nev.	302	194	76	16	10	6	17
Ogden, Utah	31	23	5	3	-	-	3
Phoenix, Ariz.	65	31	18	9	4	3	-
Pueblo, Colo.	37	31	6	-	-	-	3
Salt Lake City, Utah	117	84	19	5	3	6	15
Tucson, Ariz.	200	145	31	19	4	1	24
PACIFIC	1,629	1,165	305	91	39	29	159
Berkeley, Calif.	14	7	6	-	1	-	-
Fresno, Calif.	166	125	28	9	2	2	12
Glendale, Calif.	8	8	-	-	-	-	1
Honolulu, Hawaii	62	43	11	6	1	1	3
Long Beach, Calif.	62	44	10	3	4	1	5
Los Angeles, Calif.	138	87	31	11	6	3	2
Pasadena, Calif.	35	25	5	1	1	3	7
Portland, Oreg.	130	97	23	7	2	1	19
Sacramento, Calif.	224	157	48	11	7	1	35
San Diego, Calif.	174	122	31	15	4	2	22
San Francisco, Calif.	U	U	U	U	U	U	U
San Jose, Calif.	229	169	43	9	4	4	24
Santa Cruz, Calif.	40	27	8	4	1	-	5
Seattle, Wash.	146	104	28	8	2	4	9
Spokane, Wash.	68	54	11	-	2	1	8
Tacoma, Wash.	133	96	22	7	2	6	7
TOTAL	11,855¶	8,163	2,375	770	293	251	1,026

U: Unavailable. -:No reported cases.

* Mortality data in this table are voluntarily reported from 122 cities in the United States, most of which have populations of ≥100,000. A death is reported by the place of its occurrence and by the week that the death certificate was filed. Fetal deaths are not included.

† Pneumonia and influenza.

§ Because of changes in reporting methods in this Pennsylvania city, these numbers are partial counts for the current week. Complete counts will be available in 4 to 6 weeks.

¶ Total includes unknown ages.

All *MMWR* references are available on the Internet at http://www.cdc.gov/mmwr. Use the search function to find specific articles.

Use of trade names and commercial sources is for identification only and does not imply endorsement by the U.S. Department of Health and Human Services.

References to non-CDC sites on the Internet are provided as a service to *MMWR* readers and do not constitute or imply endorsement of these organizations or their programs by CDC or the U.S. Department of Health and Human Services. CDC is not responsible for the content of pages found at these sites. URL addressess listed in *MMWR* were current as of the date of publication.

The *Morbidity and Mortality Weekly Report (MMWR)* Series is prepared by the Centers for Disease Control and Prevention (CDC) and is available free of charge in electronic format and on a paid subscription basis for paper copy. To receive an electronic copy on Friday of each week, send an e-mail message to *listserv@listserv.cdc.gov*. The body content should read *SUBscribe mmwr-toc*. Electronic copy also is available from CDC's World-Wide Web server at *http://www.cdc.gov/mmwr* or from CDC's file transfer protocol server at *ftp://ftp.cdc.gov/pub/Publications/mmwr*. To subscribe for paper copy, contact Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402; telephone 202-512-1800.

Data in the weekly *MMWR* are provisional, based on weekly reports to CDC by state health departments. The reporting week concludes at close of business on Friday; compiled data on a national basis are officially released to the public on the following Friday. Address inquiries about the *MMWR* Series, including material to be considered for publication, to Editor, *MMWR* Series, Mailstop C-08, CDC, 1600 Clifton Rd., N.E., Atlanta, GA 30333; telephone 888-232-3228.

All material in the *MMWR* Series is in the public domain and may be used and reprinted without permission; citation as to source, however, is appreciated.

☆U.S. Government Printing Office: 2002-733-100/69017 Region IV

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)
ATLANTA, GA 30333

OFFICIAL BUSINESS
PENALTY FOR PRIVATE USE $300
RETURN SERVICE REQUESTED

9907 93036 N1667DS 0001
UNIVERSITY MICROFILMS
SERIALS ACQUISTION DEPT
300 NORTH ZEEB ROAD
ANN ARBOR MI 48103-1553

FIRST-CLASS MAIL
POSTAGE & FEES PAID
PHS/CDC
Permit No. G-284